



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

GILBERT C. BLACKWELL, DC

Respondent Name

ILLINOIS NATIONAL INSURANCE CO

MFDR Tracking Number

M4-14-1750-02

Carrier's Austin Representative

Box Number 19

MFDR Date Received

FEBRUARY 14, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position summary.

Amount in Dispute: \$850.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier issued (number 25697502) a check in the amount of \$850 to account number IR 1943/786420539 on 2/15/2014, it was deposited on 2/21/2014. I have attached a copy of a payment sheet showing the payment to Casa View Chiropractic."

Response Submitted by: Dallas Worker's Compensation Service Center

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 5, 2013	CPT Code 99456-NM-WP	\$350.00	\$0.00
	CPT Code 99458-W8-WP Designated Doctor Examination for Return to Work	\$500.00	\$0.00
TOTAL		\$850.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.

4. On November 19, 2014, the Division attempted to contact the requestor and left a message on their answering machine to verify payment was received. At the time of review, the requestor had not responded to the Division's request for information.

Issues

1. Did the Designated Doctor bill for the MMI/IR and Return to Work evaluations in accordance with medical fee guideline?
2. Is the requestor entitled to reimbursement?

Findings

1. On the disputed date of service the requestor billed CPT codes 99456-NM-WP and 99456-W8-WP.
 - 28 Texas Administrative Code §134.204(j)(3) states "The following applies for billing and reimbursement of an MMI evaluation. (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be \$350."

The requestor billed CPT code 99456 because the examination was performed by a designated doctor

- 28 Texas Administrative Code §134.204(n)(6) states "The following Division Modifiers shall be used by HCPs billing professional medical services for correct coding, reporting, billing, and reimbursement of the procedure codes. The "NM" modifier is defined as "Not at Maximum Medical Improvement (MMI)--This modifier shall be added to the appropriate MMI CPT code to indicate that the injured employee has not reached MMI when the purpose of the examination was to determine MMI."

A review of the requestor's billing finds that the "NM" modifier was appended to CPT code 99456 to designate that the claimant had not reached MMI.

- 28 Texas Administrative Code §134.204(i)(1)(E) states "The following shall apply to Designated Doctor Examinations. (1) Designated Doctors shall perform examinations in accordance with Labor Code §§408.004, 408.0041 and 408.151 and Division rules, and shall be billed and reimbursed as follows: (E) Ability of the employee to return to work shall be billed and reimbursed in accordance with subsection (k) of this section, with the use of the additional modifier 'W8'."
- 28 Texas Administrative Code §134.204(n)(23) defines the "W8" modifier as "Designated Doctor Examination for Return to Work--This modifier shall be added to the appropriate examination code performed by a designated doctor when determining the ability of employee to return to work."
- 28 Texas Administrative Code §134.204(k) states "The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier "RE." In either instance of whether MMI/IR is performed or not, the reimbursement shall be \$500 in accordance with subsection (i) of this section and shall include Division-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee."

A review of the submitted medical billing finds that the requestor did not append the "RE" modifier in accordance with 28 Texas Administrative Code §134.204(k); therefore, the requestor did not bill for the return to work examination in accordance with the medical fee guideline.

2. Per the medical fee guideline, the MAR for the MMI examination is \$350.00 and \$500.00 for the return to work examination for a total of \$850.00. Based upon the submitted documentation the respondent paid \$850.00. Therefore, the requestor is not due any additional reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

11/21/2014
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.